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JOE A. JACKSON, M.D.

March 14, 2006

TO: Mr. Woody Pringle

PATIENT: Kasey Alves

Dear Mr. Pringle:

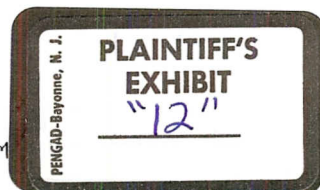
Kasey D. Alves is a pleasant 32 year old African American male who presents with a history of being forcefully restrained in a chair while in custody of the Harrison County Sheriff's Department. Apparently earlier that day, he had gotten somewhat intoxicated at the Imperial Palace. He was delivered from there to the Sheriff's Department where he was forcefully restrained in a chair, sitting for 7 hours. Strap marks are still evident above the knee and at the ankles and also scars over both shoulders in the apex area of the trapezius and more laterally in the right shoulder.

As a result of this treatment, the patient had to be transported to Memorial Hospital at Gulfport where he was found to have severe rhabdomyolysis - This is a condition of muscle enzyme breakdown and destruction indicating significant ischemic injury to the muscle and nerves. Because of the severity of the rhabdomyolysis, he ultimately developed kidney failure (a common complication of this high of an elevation of muscle enzymes). He was treated appropriately with acute renal dialysis by Dr. Doug Lanier.

While hospitalized, he apparently was seen by Dr. Paul Mace, who suggested the probability of the ischemic injuries to the nerve of the right leg and ultimately was seen by Dr. Grow. Unfortunately, Dr. Grow's records are not available for our review but discharge notes appear to indicate that a nerve conduction study and probable EMG was completed; the patient describes both. As a result of this, he was told that he had a peroneal nerve injury; however, his injury is more complex than simply a peroneal nerve dysfunction.

He continues to have a significant foot drop when walking and paradoxically favors the left leg when he steps. He does have to abduct and circumduct the right leg to overcome the foot drop which is present. The patient has had a past history of cardiac murmur, although, I did not hear it. He does have symptoms suggestive of obstructive sleep apnea; however, he is thin with a normal neck so it is very unlikely that the sleep apnea is significant at this time. Should he continue to snore and continue to have difficulty with sleep, a sleep study someday may be warranted (this, of course, unrelated to the trauma that he received at the jail on January 7, 2006). Otherwise, his review of systems is unremarkable.

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Clinical examination shows a healthy, muscular appearing 32 year old who looks his stated age. HEENT examination was unremarkable. There was no thyroid enlargement and no lymphadenopathy. He still has a cut-down scar in the left neck from where the subclavian or carotid vein was used as a site most likely for the renal dialysis. Chest and lungs were clear to auscultation and percussion. Cardiovascular system showed a normal sinus rhythm with no evidence of murmur or gallop at this time. Abdomen was soft and nontender without significant abnormality. Genitoretal exam was not performed. Neck, mid and low back had full range of motion. Straight leg raising was unremarkable. Most noteworthy is the obvious atrophy in both the anterior and posterior compartments of the right leg. This is further demonstrated by measuring 9 cm below the tibial tuberosity, bilaterally, on the left nondominant leg it is 36 cm and on the right dominant leg (that usually should be a cm larger) he is almost 2 cm smaller at 34 ½ cm. Clearly, significant atrophy of both the anterior peroneal and posterior compartment is present. This is further characterized on direct clinical examination where he clearly has a partial foot drop. He can resist some effort, which is a good sign, as it indicates that his peroneal nerve remains intact and will most likely regrow over time. He can do somewhat better with plantar flexion of the right leg but he cannot walk on his heels or toes without this leg giving way. In contradistinction, there is no motor weakness of the left leg, either upper or lower. There does not appear to be any quadriceps involvement or any other definite weakness above the knee, even though one of the most severe ligature marks was clearly around and above the knee in location. He has sensory loss that expands the sural, peroneal and tibial distributions of the distal foot. It is almost a stocking pattern of loss consistent with the ligature constriction and damage. Coordination and gait, other than the antalgic nature and the foot drop is unremarkable. His reflexes are extremely brisk, almost pathologically brisk at all sites except for the right ankle, which is absent. Both toes remain downgoing so I do not know the cause of his brisk reflexes, perhaps it is his muscular build. Otherwise, there are no other significant clinical findings on neurological exam.

IMPRESSION/RECOMMENDATIONS: My impression is that Kasey D. Alves presents with classic findings of the ligature constriction at or below the knee. This is involving basically all the sensory nerves below this level, including the continuation of the femoral nerve "the saphenous", the sural nerve, peroneal and posterior tibial. He also clearly has significant weakness in both peroneal and tibial distributions affecting plantar flexion of the foot to a significantly less degree than dorsiflexion of the foot with a partial foot drop present. Since there continues to be function and resistance against effort in gravity, giving a 4/5 weakness in both groups, this clearly indicates that nerve function is present and should gradually return. Fortunately, at this point in time, he is not avoiding touching the leg. He is keeping it stimulated and he is showing no development of reflex sympathetic dystrophy, the most feared complication of this type of nerve injury. Continued follow up with EMG/nerve conduction studies would be helpful over time. We cannot provide this service, however, as we are terminating our practice. We would suggest Dr. Beau Bowen as the most experienced neurologist in the area with these studies. We would not suggest return to a neurologist not boarded in EMG/nerve conduction studies.

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In terms of treatment options, he should continue stimulating this leg, continue to use it as normal as possible. I have given him a prescription for an AFO, if he chooses to use it. Most people prefer not to use foot drop braces if they can avoid it, particularly since this is likely to recover someplace between 9 months to 2 years, post injury. Hopefully, since this was a constriction lesion, it may be quicker than this, although, generally that type of compression lesion resolves within the first month to two months indicating that this is more likely principally axonal and therefore, requires regrowth of nerves for recovery.

We will also give him prescription for Lyrica, a medicine helpful for neuritic pain, allowing him to go up to 75 mg three times a day if this is beneficial. If it is beneficial, he will need to continue follow up with a neurologist of his choice. Lyrica is not generally renal toxic and should not further compromise his kidneys. He should avoid all Tylenol and Tylenol based pain medications due to the real risk of continued kidney dysfunction.

We do appreciate the opportunity to see this complex and challenging patient.



Joe A. Jackson, M.D., ACP, FAES, FCSS, FASDA
DICTATED BUT NOT READ

JAJ/pmts